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	17E254	A. BUILDING _____ B. WING _____	09/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATCHISON SENIOR VILLAGE	1419 N 6TH ST ATCHISON, KS 66002

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and complaint investigation #KS59801.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: The facility identified a census of 46 residents. The sample included 23 residents. Based on observation, staff interview and record review the facility failed to provide an ongoing activities program for 1 of 3 residents (#51). Findings included: - Resident #51's Significant Change Minimum Data Set (MDS) 3.0 dated 9/04/12 recorded a Brief Interview for Mental Status Score of 2 indicating the resident had severely impaired cognition. The resident required limited assistance with bed mobility and walking, extensive assistance with transfers, locomotion, dressing, toilet use and hygiene. The MDS documented that animals/pets, going outside for fresh air and favorite activities were very important to the resident. The Care Plan for aggression with revision date 9/5/12 indicated the resident liked to walk. Staff	F 248		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 248	Continued From page 1	F 248		

had tried television, snacks, magazines and he/she did not seem interested. The care plan did not provide specific goals or interventions based on the resident's individual interests.

The Care Plan for activities dated 8/13/12 with a goal for staff to walk the resident to at least 1-3 activities per week directed staff to remind the resident of activities, encourage him/her to walk to activities and offer activities of choice. The care plan did not direct staff on what activities the resident preferred.

The Activity Assessment without a date indicated the resident was interested in classical and jazz music, liked baseball, football, basketball, golf, cooking food, sometimes bingo, television, Daisy, his/her dog, Lutheran group and visiting.

The Daily Participation Record dated August 2012 indicated staff documented the resident participated passively in manicures twice that month, current events daily, music three times that month, socials one time that month and movies thirteen times that month. He/She actively participated daily in family visits. Staff provided documentation of one on one visits conducted five times for the month of August 2012. Staff failed to document inviting the resident to bingo, religious/Bible study, dog/animal visits or sports.

The Daily Participation Record for September 2012 indicated staff documented the resident passively participated one time in music, one time in special events and eight times in family visits from 9/1/12 - 9/11/12.

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Observation on 9/10/12 at 8:05 A.M. the resident sat on the couch in the television room with other residents.

Observation on 9/10/12 from 9:00 A.M. - 10:07 A.M. revealed the resident sat on the couch in the television room, slumped over and awake with no activity offered.

Observation on 9/10/12 at 10:35 A.M. revealed the resident sat in a cooking activity, eating.

Observation on 9/10/12 at 11:00 A.M. revealed the resident sat in the common area in the wheelchair by the nurse's desk not engaged in any activity. Devotions were being conducted during this time and staff did not encourage the resident to attend that activity.

Observation on 9/10/12 at 2:57 P.M. the resident sat by the nurse's desk not involved in any activity.

Observation on 9/10/12 at 4:53 P.M. revealed the resident sat in the wheelchair in common area not involved in any activities.

Observation on 9/11/12 at 11:00 A.M. the resident sat in the common area by the nurse's station not engaged in any activity. Devotions were being conducted at that time and staff did not encourage the resident to attend that activity.

Observation on 9/11/12 at 3:54 P.M. the resident sat in the wheelchair by the nurse's desk attempting to get up from the wheelchair. Staff encouraged him/her to sit back down. The resident was not involved in an activity and staff

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F 248	Continued From page 3 did not offer him/her an activity. During an interview on 9/11/12 at 1:53 P.M. direct care staff L reported the resident's significant other read the paper to him/her and visited with him/her at times. The resident attended bingo with his/her significant other, most of the time the resident walked around the facility. During interview on 9/11/12 at 2:29 P.M. licensed nursing staff F reported the resident attended cooking activities and ate, he/she also liked foot ball and walking or sitting outside with his/her significant other or staff. The resident's significant other informed staff the resident enjoyed getting down on the floor and used to fix floors in the past. Based on observation and interview the facility failed to provide an on going activity program to meet this resident's mental and psychosocial needs.	F 248		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279		

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F 279	Continued From page 4 highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: The facility identified a census of 46 residents. The sample included 23 residents. Based on observation, staff interview and record review the facility failed to develop an individualized comprehensive care plan for 2 of 23 residents sampled (#51, #13) Findings included: - Resident #51's Significant Change Minimum Data Set (MDS) 3.0 dated 9/04/12 recorded a Brief Interview for Mental Status Score of 2 indicating the resident had severely impaired cognition. The resident required limited assistance with bed mobility and walking, extensive assistance with transfers, locomotion, dressing, toilet use and hygiene. The MDS documented that animals/pets, going outside for fresh air and favorite activities were very important to the resident. The Care Plan for aggression with revision date 9/5/12 indicated the resident liked to walk. Staff had tried television, snacks, magazines and he/she did not seem interested. The care plan did not provide specific goals or interventions based on the resident's individual interests.	F 279		

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F 279	Continued From page 5 The Care Plan for activities dated 8/13/12 with a goal for staff to walk the resident to at least 1-3 activities per week directed staff to remind the resident of activities, encourage him/her to walk to activities and offer activities of choice. The care plan did not direct staff on what activities the resident preferred. The Activity Assessment without a date indicated the resident was interested in classical and jazz music, liked baseball, football, basketball, golf, cooking food, sometimes bingo, television, Daisy, (his/her dog), Lutheran group and visiting. Observation on 9/10/12 at 8:05 A.M. the resident sat on the couch in the television room with other residents with no activity offered. The resident fell asleep on the couch. Observation on 9/10/12 at 2:57 P.M. the resident sat by the nurse's desk not involved in any activity. During an interview on 9/11/12 at 1:53 P.M. direct care staff L reported the resident's significant other read the paper to him/her and visited with him/her at times. The resident attended bingo with his/her significant other, most of the time the resident walked around the facility. During interview on 9/11/12 at 2:29 P.M. licensed nursing staff F reported the resident attend cooking activities and ate. He/She also liked football and walked outside with his/her significant other or staff. The resident's significant other informed staff the resident enjoyed getting down on the floor and used to fix floors in the	F 279		

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past.

During interview on 9/11/12 at 3:14 P.M. licensed nurse K reported he/she did not develop a care plan for resident activities. Licensed staff K acknowledged the activity care plan did not direct staff on what the resident's activity preferences were and failed to individualize interventions to meet the resident's needs based on the recent activity assessment.

The facility failed to provide a policy for the development of comprehensive care plans.

The facility failed to develop an individualized activity care plan for this resident.

- Resident #13's quarterly Minimum Data Set 3.0 Assessment (MDS) dated 6-14-12 documented the resident with a Brief Interview for Mental Status Score (BIMS) score of 15, which indicated the resident was independent with decision making and cognition, required extensive assistance with bed mobility, locomotion, personal hygiene and required total assistance with transfers, toilet use and bathing.

The 3-19-12 Psychosocial Drug Use Care Area Assessment (CAA) documented the resident received antidepressants, a hypnotic, anti anxiety, and psychotropic medications with possible side effects, and his/her mood varied.

The updated 7-23-12 care plan documented the resident received anti-anxiety, anti-depressant,

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F 279	Continued From page 7 hypnotic, and pain medication and directed his/her own care. The care plan lacked non-pharmacological interventions to enhance and encourage sleep. Record review of the September 2011 Medication Administration Record (MAR) revealed the resident received Ambien (a hypnotic medication used for sleeping) each night. Observation on 9-10-12 at 9:15 A.M. revealed the resident sat in a wheelchair outside on the patio and smoked a cigarette. The resident was calm and talkative. Observation on 9-10-12 at 3:15 P.M. revealed the resident laid in bed with his/her eyes closed. During staff interview on 9-11-12 at 3:30 P.M. administrative nurse C acknowledged the resident's care plan lacked non-pharmacological interventions for Ambien and stated the resident directed his/her own bedtime cares such as having the pillows as he/she wished, have TV or radio on etcetera (etc.). He/she stated the resident received Ambien every night at bedtime and requested Percocet (a narcotic pain medication) at bedtime also. The facility failed to provide a policy regarding the development of a comprehensive care plan. The facility failed to develop an individualized comprehensive care plan for this resident's use of Ambien at bedtime for sleep.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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F 280	Continued From page 8 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility identified a census of 46 residents. Sample size included 23 residents. Based on observation, record review, and interview, the facility failed to revise the care plan for 1 (#19) resident of the sample. Findings included: - Review of resident #19's September 2012 Physician order sheet identified the resident received 81 milligrams of aspirin each day. The resident's annual Minimum Data Set 3.0 (MDS) dated 6/27/12 identified the resident had	F 280		

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F 280	Continued From page 9	F 280		

moderately impaired vision, short and long term memory problems, moderately impaired cognition and displayed physical behaviors toward others. The MDS included the resident required extensive staff assistance with bed mobility, walking in the corridor, dressing, eating, toilet use, personal hygiene, did not walk in the room and was totally dependent upon staff for locomotion on and off the unit. The MDS did not identify the resident had any skin issues.

The resident's activities of daily living functional/rehabilitation care area assessment dated 6/28/12 included the resident needed staff assistance with all activities of daily living due to poor fine motor skills, required support with all standing transfers and primarily used the wheelchair which staff propelled.

The resident's care plan dated 6/25/12 included the resident was at risk for alteration in skin integrity, staff monitored the resident for skin conditions, staff used caution during transfers and when they propelled the resident through doors and staff placed the resident's feet on the pedals of his/her wheelchair prior to propelling the resident. An entry dated 8/8/12 included the resident received a skin tear on his/her left arm during a transfer, staff used caution during transfers and the resident had thin skin. An entry dated 8/25/12 included staff transferred the resident with a sit to stand lift and used caution to not bump the resident's arms and head during transfers. The resident's care plan did not address the resident's bruises on his/her arms/hands.

A nurse's note dated 5/15/12 and timed 10:30

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F 280	Continued From page 10 A.M. included the resident's skin was warm, dry and intact and the resident occasionally had bruises to his/her arms and hands which could be due to the resident being combative, swung at staff or pounded his/her hands or arms on the table in anger or stress. On 9/10/12 at 8:25 A.M. the resident sat in the dining room, eating breakfast. Observation revealed the resident had bruises on his/her arms bilaterally. On 9/11/12 at 7:15 A.M. the resident sat in the hallway next to a handrail. During an interview with administrative nursing staff C on 9/10/12 at 3:10 P.M. staff confirmed the resident's hands had bruises bilaterally and the staff did not know the causes of the bruises. During an interview with administrative nursing staff D on 9/11/12 at approximately 1:50 P.M. staff stated he/she did not know the causes of the bruises on the resident's hands, the resident had a tendency to sit by the handrail, hitting the handrail in an attempt to stand, which may have caused the bruises on the resident's hands. During an interview with administrative nurse staff C on 9/11/12 at approximately 1:55 P.M. staff confirmed the staff failed to revise the resident's care plan to include the bruises on the resident's hands and lower arms. The facility failed to revise this resident's care plan to include the bruising on the resident's hands/lower arms.	F 280		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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F 309 SS=D	Continued From page 11 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: The facility had a census of 46 residents. The sample included 23 residents. Based upon observation, record review and interviews the facility failed to implement interventions to prevent bruises and skin tears for 1 (#19) of the 3 residents sampled for skin conditions. Findings included: - Review of resident #19's September 2012 Physician order sheet identified the resident received 81 milligrams of aspirin each day. The resident's annual Minimum Data Set 3.0 (MDS) dated 6/27/12 identified the resident had moderately impaired vision, short and long term memory problems, moderately impaired cognition and displayed physical behaviors toward others. The MDS included the resident required extensive staff assistance with bed mobility, walking in the corridor, dressing, eating, toilet use, personal hygiene, did not walk in the room and was totally dependent upon staff for locomotion on and off the unit. The MDS did not identify the resident had any skin issues.	F 309		

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The resident's activities of daily living functional/rehabilitation care area assessment dated 6/28/12 included the resident needed staff assistance with all activities of daily living due to poor fine motor skills, required support with all standing transfers and primarily used the wheelchair which staff propelled.

The resident's care plan dated 6/25/12 included the resident was at risk for alteration in skin integrity, staff monitored the resident for skin conditions, staff used caution during transfers, when they propelled the resident through doors and staff placed the resident's feet on the pedals of his/her wheelchair prior to propelling the resident. An entry dated 8/8/12 included the resident received a skin tear on his/her left arm during a transfer, staff used caution during transfers and the resident had thin skin. An entry dated 8/25/12 included staff transferred the resident with a sit to stand lift and used caution to not bump the resident's arms and head during transfers.

A nurse's note dated 5/15/12 and timed 10:30 A.M. included the resident's skin was warm, dry and intact and the resident occasionally had bruises to his/her arms and hands which could be due to the resident being combative, swung at staff or pounded his/her hands or arms on the table in anger or stress.

A facsimile note to the resident's physician dated 8/8/12 (time unknown) included the facility initiated the standing order for skin tears and the resident had a skin tear on his/her left arm.

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A nurse's note dated 8/8/12 and timed 8:00 P.M. included the resident received a skin tear on his/her left arm during transfer in the sit to stand lift.

A facsimile note to the resident's physician dated 8/25/12 (time unknown) included the resident bumped his/her head on the sit to stand lift and had a large raised area on his/her forehead.

A nurse's note dated 8/25/12 and timed 11:00 A.M. included at 8:30 A.M. the resident hit his/her head on sit to stand lift and had a raised area on his/her forehead.

On 9/10/12 at 8:25 A.M. the resident sat in the dining room eating breakfast. Observation revealed the resident had bruises on his/her lower arms and hands bilaterally.

On 9/10/12 at 9:22 A.M. staff pushed the resident from the dining room to the nurse's station and the resident's feet were not on the wheelchair pedals. Observation also revealed the resident had a gauze bandage on his/her left arm.

On 9/10/12 at 12:40 P.M. direct care staff M and O transferred the resident from the wheelchair to the bed via the sit to stand lift.

On 9/11/12 at 7:15 A.M. the resident sat in the hallway next to a handrail.

On 9/11/12 at 2:00 P.M. licensed nurse G removed the gauze bandage from the resident's left arm. Observation revealed the skin tear healed, the resident had a purple colored bruise on his/her left arm about the size of a half dollar

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and the area was swollen. During an interview with licensed nurse G at that time the staff stated the swelling and bruise were resulted from the skin tear. Licensed nurse G stated the resident did not wear protective clothing/devices on his/her upper extremities prior to the skin tear.

During an interview with administrative nursing staff C on 9/10/12 at 3:10 P.M. staff confirmed the resident's hands had bruises bilaterally and the staff did not know the causes of the bruises.

During interview with administrative nursing staff D on 9/11/12 at approximately 1:50 P.M. the staff stated at one point the resident wore geri-sleeves (protect against busies/skin tears), the resident did not like the geri-sleeves and therefore staff discontinued the sleeves. Nursing administrative staff D stated he/she did not know the causes of the bruises on the resident's hands, the resident had a tendency to sit by the handrail, hitting the handrail in an attempt to stand which may have caused the bruises on the resident's hands. Administrative nursing staff D stated the facility did not document when the facility attempted the sleeves nor the reason the facility discontinued the sleeves.

During an interview with administrative nurse staff C on 9/11/12 at approximately 1:55 P.M. staff stated the care plan did not include the resident's refusal to wear protective sleeves and he/she was not aware the resident ever wore protective sleeves to minimize bruising/skin tears.

During interview with licensed nurse D on 9/11/12 at approximately 1:58 P.M. staff stated the resident wore tube (gauze dressing) on his/her

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F 309	Continued From page 15 arms bilaterally at one time, the tube seemed to work for a while but the tube rolled down and the facility discontinued it. The facility failed to implement interventions to minimize bruising and skin tears for this dependent resident who was at risk for skin issues.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility had a census of 46 residents. The sample included 23 residents. The facility identified 9 independently mobile and cognitively impaired residents. Based upon observation, record review and interviews the facility failed to prevent an elopement for 1 (#51) of 3 residents sampled for supervision of accidents. Findings included: - Review of resident #51's September 2012 Physician's Order Sheet identified the resident had diagnoses that included: history of falls, abnormality of gait, altered mental status and paralysis agitans (Parkinson's disease).	F 323		

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The resident's admission Minimum Data Set (MDS) 3.0 dated 8/12/12 identified the resident scored 9 (moderately impaired cognition) on the Brief Interview for Mental Status, and had inattentive and disorganized thinking. The MDS identified the resident without wandering tendencies and required extensive staff assistance with bed mobility, transfers, walking in the room/corridor, locomotion on and off the unit, dressing, toilet use and personal hygiene. The MDS recorded the resident not steady when moving from seating to standing position, walking, turning around, moving on and off the toilet and surface to surface transfers and utilized a walker and wheelchair. The MDS coded the resident fell the last month prior to admission, the prior 2-6 months before admission, and had 2 non-injuries and 1 non-major injury fall since admission.

The resident's fall care area assessment (CAA) dated 8/12/12 included the resident was unsteady at times, the resident's gait varied and the resident required 1- 2 staff to stand and walk dependent upon the resident's abilities. The CAA included the resident utilized a wheelchair at times, had altered mental status, history of falls and did not have good safety awareness.

The resident's wander data collection tool dated 7/31/12 identified the resident not at risk for elopement.

The resident's fall risk assessment dated 8/1/12 identified the resident scored 19 (according to the legend a score of 10 or above represented the resident at high risk for falls).

The resident's elopement risk assessment dated

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8/1/12 included the resident not an elopement risk, had impaired cognition with poor decision making skills, did not express to go home, no history of elopement while he/she resided at home, no history of leaving the facility without supervision, did not wander aimlessly, and had not wandering and/or seeked family member or spouse.

The resident's care plan dated 8/13/12 included the resident had impaired cognition, the resident's gait had improved, the resident utilized a walker and a wheelchair. The care plan included the resident was at risk for falls, the resident attempted to stand without asking for staff assistance and 1-2 staff walked the resident using a gait belt. The care plan included staff monitored the resident for restlessness, and the resident was kept within staff view due to his/her restlessness. An entry to the resident's care plan dated 8/18/12 included staff provided oversight when the resident ambulated due to the resident attempted to enter other residents' rooms and offices.

The resident's physician progress note dated 9/12/12 included the resident had severe dementia.

Review of the resident's nurse's notes revealed the resident fell 5 times from 8/1/1 to 8/22/12.

A nurse's note dated 8/16/12 and timed 3:30 A.M. documented the resident in the hallway in his/her wheelchair, the resident attempted to open doors and did not stay seated in the wheelchair and staff wheeled the resident to the nurse's desk.

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A nurse's note dated 8/18/12 and timed 2:00 P.M. documented the resident stated he/she wanted to go home and the resident was on 1:1 today.

The resident's clinical record lacked evidence the facility reassessed the resident's elopement risk since the resident's experienced signs of aimlessly wandering. stated he/she wanted to go home, and the resident ambulation skills had improved since the elopement risk assessment dated 8/1/12.

During interview with nursing administrative staff D on 9/13/12 at 1:00 P.M. staff stated he/she did not know why or how long the facility had the resident on 1:1 on 8/18/12. Nursing administrative staff stated the facility performed elopement risk assessments upon admission, quarterly and when a resident experienced a significant change. Nursing administrative staff D confirmed the facility did not perform an elopement risk assessment on the resident although the resident stated he/she wanted to go home on 8/18/12 and attempted to open doors on 8/16/12.

A nurse's note dated 8/22/12 timed 2:45 P.M. documented that at 1:20 P.M. staff was informed a resident fell outside, staff exited the facility and observed the resident sitting in the grass, had taken his/her socks off, and an individual was with the resident. The licensed nurse asked the individual if he/she saw the resident fall and the individual stated no but saw the resident crawled down the hill.

A nurse's note dated 8/22/12 timed 3:30 P.M. documented a neighbor entered the facility and

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alerted the facility a resident was outside. The note included another neighbor stayed with the resident and reported to facility staff the resident crawled down the hill. The note included at approximately 1:20 P.M. the wireless call system received a page the back door alarmed. Direct care staff saw the resident less than 5 minutes before the elopement and a licensed nurse saw the resident 10 minutes before the resident eloped from the facility.

On 9/10/12 at 8:39 A.M. the resident ambulated by the nurse's desk independently without his/her walker, the resident walked in circles and staff did not attempt to re-direct the resident.

On 9/10/12 at 3:02 P.M. staff walked with the resident without a walker or a gait belt. Further observation revealed the resident had on socks, ambulated at a steady fast pace and staff attempted to catch up to the resident.

On 9/13/12 at approximately 8:30 A.M. the resident had a wander-guard on directly above his/her left ankle.

On 9/13/12 at approximately 9:40 A.M. observation revealed a keypad located next to the exit door identified by the facility as the back door. Further observation revealed if a code was not entered into the keypad, the back exit door alarmed and sent a page to the wireless call light system.

On 9/13/12 at 10:30 A.M. observation with direct care staff XX2, he/she identified the place where they found the resident. He/she identified the resident was located on the ground

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approximately 50 feet from the back exit door and approximately 15 feet from a street that led to a residential area.

On 9/13/12 at 11:43 A.M. the resident sat in his/her wheelchair at the dining room table and observation revealed the resident non-interviewable.

According to the National Weather Service, the temperature in Atchison, Kansas was 90 degrees Fahrenheit between 1:20 P.M. and 1:30 P.M. on 8/22/12.

During interview with maintenance staff XX1 on 9/13/12 at approximately 8:40 A.M. staff stated the magnetic lock on the back door was faulty and did not send an audible sound when the resident opened the back door (door located between the 200 and 300 hall breezeway). Maintenance staff XX1 stated the wireless call system received the page someone had opened the door. Maintenance staff XX1 stated the door alarms and the wireless call system were not wired to the same system. Maintenance staff XX1 stated on 8/22/12 resident #51 did not utilize a wander guard bracelet. Maintenance staff XX1 stated he/she checked the exterior door alarms on a monthly basis and he/she last checked the exterior door alarms on 8/9/12 and the door alarm sounded on that date. Maintenance staff XX1 stated the faulty magnetic lock was repaired on 8/22/12 at approximately 3:30 P.M.

During interview with maintenance staff XX1 on 9/13/12 at approximately 8:40 A.M. staff stated that at approximately 1:20 P.M. on 8/22/12 he/she observed an empty wheelchair located on the

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sidewalk approximately 15 feet from the back exit door. Maintenance staff XX1 stated at that time direct care staff XX2 exited a resident ' s room located at the end of 200 hall and he/she asked direct staff XX2 why a resident's wheelchair was outside the exit door and at that time direct care staff XX3 came down the hall and informed them a resident was outside on the grass. Maintenance staff XX1 stated he and the other staff exited the back door at that time and observed resident #51 on the ground on the other side of the hill (approximately 45-50 feet from the exit door).

During interview with direct care staff XX2 on 9/13/12 at 9:04 A.M. staff stated he/she assisted a resident in his/her room located near the end of 200 hall on 8/22/12 at approximately 1:20 P.M., he/she saw resident #51's wheelchair outside the window of the resident's room he/she assisted. Direct care staff XX2 stated resident #51 not in the wheelchair and he/she thought the resident's family had taken the resident out of the facility. Direct care staff XX2 stated he/she received a page on his/her beeper via the wireless call system that the back door opened as he/she assisted the resident toward the end of the 200 hall, and he/she continued to assist the resident. Direct care staff XX2 stated after he/she exited the resident's room (the resident he/she assisted), direct care staff XX3 alerted him/her that a neighbor had entered the facility and alerted the facility a resident was on the ground outside and he/she alerted the licensed nurse, he/she and other staff exited the back door and resident #51 sat on the ground on the other side of the hill. Direct staff XX2 stated he/she was unaware the resident was outside of the facility

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unassisted until direct care XX3 informed him/her.

During interview with licensed nurse G on 9/13/12 at approximately. 9:40 A.M. the staff stated he/she was on duty at the time the resident eloped from the facility. Licensed nurse G stated his/her her beeper did not alert him/her the back door exit alarmed. Licensed nurse G stated direct care staff XX2 alerted him/her a man was outside and he/she exited the back door and resident #51 was on the ground. Licensed nurse G stated the resident's wheelchair was approximately 5 feet from the exit door and the resident sat on top of the hill approximately 35 feet from the exit door. Licensed nurse G stated he/she was unaware resident #51 was outside of the facility unassisted until notified by direct staff XX2.

During interview with direct care staff XX3 on 9/13/12 at approximately 10:15 A.M. staff stated a female neighbor entered the front entrance of the facility on 8/22/12 at approximately 1:20 P.M. and stated a man was on the ground outside. Direct care staff XX3 stated he/she immediately informed direct care staff XX2 a man was outside and he/she was later informed resident #51 exited the back door without staff knowledge.

During interview with administrative staff A on 9/13/12 at approximately 10:30 A.M. staff stated according to the wireless call system log the back door opened without a code at 13:22:14 and the door started to close at approximately 13:22:16. Administrative staff A stated he/she did not know when the staff responded to the wireless call system. Administrative staff D stated the facility

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F 323	Continued From page 23 implemented the wireless call system approximately 6 weeks ago and it was not the facility's intent the wireless call system would back up the audible alarm system. The facility's security doors policy and procedure (undated) included all exterior doors within the living areas of the facility are Mag-locked and alarmed. Door alarms are armed at all times. The facility's policy and procedure for elopement risk potential (undated) included all residents had an initial elopement risk assessment performed upon admission. Residents found to be at high risk and ambulatory with behavioral tendencies towards elopement during initial assessment would have an elopement risk assessment done quarterly unless identified not at risk. Any resident with a change in condition that affects their cognition and puts them at a higher risk for elopement must have an immediate elopement risk assessment performed and added to the next quarterly elopement risk assessment list. The policy did not address residents that exhibited signs of elopements between assessments. The facility failed to provide supervision for this cognitively impaired resident at risk for elopement and a history of falls who eloped from the facility.	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329		

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F 329	Continued From page 24 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility had a census of 46 residents. The sample included 23 residents. Based upon observation, record review and interviews the facility failed to monitor behaviors and failed to ensure the effectiveness of pain medication for 5 (#13, #18, #29, #32, #41) of the the 10 residents sampled for unnecessary drugs. Findings included: - Review of resident #32's September 2012 Physician Order Sheet (POS) included the resident had diagnoses that included: aggression (hostile behavior), pain, and dementia (loss of brain function) with behaviors. The POS included the resident had a physician's order to receive 1	F 329		

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to 2 tablets (tab) of 325 milligrams (mg) of Tylenol (pain medication) as needed (PRN) for mild to moderate pain, 10 mg of Namenda twice a day (BID) for dementia with behaviors, 125 mg of Depakote Sprinkles BID for aggression and 25 mg of Seroquel (antipsychotic medication) for aggression.

The resident's quarterly Minimum Data Set (MDS) 3.0 dated 8/6/12 identified the resident scored 9 (moderately impaired cognition) on the Brief Interview for Mental Status, without behaviors, and required extensive staff assistance with bed mobility, transfers, locomotion on and off the unit, dressing, toilet use and personal hygiene. The MDS identified the resident received antipsychotic and antidepressant medications 7 days prior to the assessment.

The resident's care plan dated 8/8/12 addressed the resident had dementia with behaviors, aggression, received Seroquel (an antipsychotic medication) and staff monitored the resident for hitting, tearfulness and agitation. The care plan included the resident received Depakote for aggression.

A psychiatrist progress note signed and dated by an Advanced Registered Nurse Practioner on 8/9/12 included staff reported the resident upset and angry, the resident started receiving Risperdal (an antipsychotic medication) on 7/3/12 due to hitting and screaming at staff. The note included to increase the resident's Namenda, start the resident on Depakote Sprinkles for mood stabilization and aggression, discontinue the Risperdal and start Seroquel for aggression.

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A consultant pharmacist's medication regimen review dated 6/14/12 included the resident had physician's orders to receive 1 to 2 tabs of Tylenol PRN every 4-6 hours and the pharmacist asked how did nursing staff consistently determine whether to give the resident 1 or 2 tabs and to consider changing or clarifying the order.

Review of the resident's September 2012 Medication Administration Record (MAR) revealed the resident received (2) 325 mg of Tylenol on 9/3/12 at 1:30 P.M. for back pain. Further review revealed staff failed to rate the resident's pain before or after staff administered the Tylenol. According to the MAR the resident received 325 mg of Tylenol on 9/7/12 at 3:40 P.M. Further review revealed staff failed to rate the resident's pain prior to administering the Tylenol to determine if the resident required 1 or 2 tabs of the Tylenol.

Review of the resident's September 2012 behavior monitoring sheet included the facility monitored the resident for yelling, anxiety and aggression. The behavior monitoring sheet did not identify the medication for the targeted behaviors.

On 9/11/12 at 10 A.M. the resident laid in bed and spoke to a nursing student and no inappropriate behaviors were observed.

During an interview with licensed nurse I on 9/11/12 at approximately 1:25 P.M. the staff stated the behavior monitoring sheet just list the resident's behaviors the facility monitored and the behaviors were not associated with any

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medications. Licensed nurse I stated the resident was combative at times and the resident's behaviors associated with his/her dementia included hitting and kicking and confirmed staff did not include those behaviors on the behavior monitoring sheet.

During an interview with nursing administrative staff D on 9/11/12 at approximately 1:00 P.M. the staff stated behavioral monitoring sheets were not drug specific and if a resident received Depakote for behaviors the resident would not have a behavioral monitoring sheet. Nursing administrative staff stated residents that received an antipsychotic medication would have a behavioral monitoring sheet but it would not be drug specific. Nursing administrative staff D confirmed the facility did not identify the medication associated with the targeted behavior.

During an interview with nursing administrative staff D on 9/11/12 at approximately 3:10 P.M. the staff stated the resident's MAR should read if staff rated the resident's pain between 1-5 administer 1 tab of Tylenol and if the resident's pain was greater than 5 administer 2 tabs of Tylenol. Nursing administrative staff D confirmed the MAR did not include a pain rating scale to determine the dosage of Tylenol for staff to administer.

The facility's behavior monitoring sheet policy (undated) included any nurse who initiated an order for a medication for behaviors initiated behavior charting via behavior monitoring sheet in the MAR.

The facility failed to monitor the efficacy of the

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resident's medications.

- Review of resident #41's Physician Order Sheet (POS) signed 8/6/12 included the resident received 250 milligrams (mg) of Depakote ER (extended release) three times a day for dementia with behaviors and 7.5 milligrams of Zyprexa (an antipsychotic) each day.

The resident's quarterly Minimum Data Set (MDS) 3.0 dated 7/11/12 revealed the resident had short and long term memory problems, moderately impaired decision making skills, required staff supervision with locomotion on and off the unit, dressing, personal hygiene and limited staff assistance with toilet use. The MDS identified the resident received antipsychotic and antidepressant medications 7 days prior to the assessment reference date.

The resident's psychotropic drug use care area assessment dated 1/25/12 included the resident received antipsychotic medications and had a diagnosis of Alzheimer's with behaviors.

The resident's care plan dated 7/12/12 included the resident received Zyprexa and Depakote.

The resident's June 2012 behavior monitoring sheet included the resident received Zyprexa for paranoia (condition of suspicious behaviors). The resident's September 2012 behavior monitoring sheet included anger as the targeted behavior for Zyprexa.

Review of the resident's clinical record lacked

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evidence to support the facility monitored the resident's behaviors associated with dementia. The clinical record also lacked evidence to support the facility monitored targeted behaviors for the Depakote.

On 9/10/12 at 2:10 P.M. the resident attended bible studies and did not display any inappropriate behaviors.

During interview with licensed nurse F on 9/10/12 at approximately 2:05 P.M. the staff stated the facility did not monitor behaviors associated with Depakote. Licensed nurse F stated the resident became angry and was aggressive with staff at times if staff attempted to redirect the resident.

During interview with nursing administrative staff D on 9/11/12 at approximately 1:00 P.M. the staff stated behavioral monitoring sheets were not drug specific and if a resident received Depakote for behaviors the resident would not have a behavioral monitoring sheet. Nursing administrative staff stated residents that received an antipsychotic medication would have a behavioral monitoring sheet but it would not be drug specific. Nursing administrative staff D confirmed the facility did not identify the medication associated with the target behavior.

The facility's behavior monitoring sheet policy (undated) included any nurse who initiated an order for a medication for behaviors initiated behavior charting via behavior monitoring sheet in the MAR.

The facility failed to monitor the efficacy of the resident's medications.

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- Resident #13's quarterly Minimum Data Set 3.0 Assessment (MDS) dated 6-14-12 documented the resident with a Brief Interview for Mental Status Score score of 15, which indicated the resident was independent with decision making and cognition, required extensive assistance with bed mobility, locomotion, personal hygiene and required total assistance with transfers, toilet use and bathing.

The 3-19-12 Psychosocial Drug Use Care Area Assessment (CAA) documented the resident received antidepressants, a hypnotic, anti anxiety, and psychotropic medications with possible side effects, and his/her mood varied.

The updated 7-23-12 care plan documented the resident received anti-anxiety, anti-depressant, hypnotic, and pain medication and directed his/her own care.

The updated 6-13-12 Atypical Antipsychotic Use form in the care plan documented the resident received Abilify (an anti-psychotic medication) for bipolar diagnosis (a psychiatric disorder) and the staff would encouraged activities, 1:1 visits, TV, and directed staff to report negative comments, remind the resident not to scream at staff or call them names, inform the charge nurse when behavior was inappropriate, and the resident became upset at times when he/she had to wait for smoking time. The Target Behavior section of the facility form documented the resident received Valium (an antianxiety medication) for the diagnosis of anxiety and insomnia. The resident napped after lunch, requested antianxiety

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medication as needed and staff encouraged the resident to express his/her concerns, feelings, and fears.

The September 2012 Medication Administration Record (MAR) revealed the resident received Depakote 750 milligrams (mg) twice (BID) daily for bipolar, Effexor 75 mg BID for depression, Valium 1 mg three (TID) times daily for anxiety, Abilify 5 mg daily for bipolar, and Cymbalta 30 mg daily for depression.

The nurse's note (NN) dated 5-10-2 at 1:00 P.M. documented the resident was rude and threatened to hit staff.

The NN on 5-19-12 at 11:00 A.M. documented the resident became upset and yelled at staff.

The NN on 8-24-12 at 2:30 P.M. documented the resident had increased episodes of yelling and made inappropriate comments to staff.

The July, August, and September 2012 Behavior Monitoring Sheets documented the behavior of anxiety and the resident received Abilify, had insomnia, had anxiety and received Valium, and had outbursts. The clinical record lacked evidence the facility monitored specific behaviors related to the use of the antipsychotics, antidepressants and antianxiety medications.

Observation on 9-10-12 at 9:15 A.M. revealed the resident sat in a wheelchair outside on the patio and smoked a cigarette. The resident was calm and talkative.

Staff interview on 9-11-12 at approximately 1:36

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P.M. licensed nurse I reviewed the MAR and stated staff documented behaviors displayed by the resident on the behavior monitoring flow sheet in the MAR.

Staff interview on 9-11-12 at 3:30 P.M. administrative nursing staff C acknowledged the behavior monitoring sheet lacked specific behaviors related to each medication used for the behaviors the resident displayed which required the medication.

The undated facility provided Behavior Monitoring Sheet Policy documented when staff received an order for a medication for behaviors, staff documented on the behavior monitoring sheet in the MAR.

The facility failed to monitor specific targeted behaviors for this resident who received multiple antipsychotic, antianxiety, and antidepressant medication.

- Resident #18's quarterly Minimum Data Set 3.0 Assessment (MDS) dated 8-5-12 documented the resident's Brief Interview for Mental Status Score (BIMS) of 15, which indicated the resident was independent with decision making and cognitively intact.

The updated 8-9-12 care plan documented the resident received Seroquel (an antipsychotic medication) for psychosis and directed staff to monitor for behaviors circled and no behaviors were circled. The care plan documented the resident made negative comments about dying

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and directed staff to reassure the resident regarding health concerns, encourage to attend events, allow to voice concerns, and redirect to pleasant topics.

Record review of the September 2012 Medication Administration Record (MAR) revealed the resident received Seroquel 25 milligrams (mg) daily.

Record review of the July, August, and September 2012 Behavior Monitoring Flow sheets documented the resident had anxiety and received Valium. The medical record lacked evidence the facility monitored targeted behaviors for the Seroquel.

Observation on 9-10-12 at 4:15 P.M. revealed the resident laid in bed with his/her eyes closed.

During staff interview on 9-11-12 at 11:29 A.M. direct care staff N stated the resident was cooperative with cares and was not aware of any behavior problems concerning the resident.

During staff interview on 9-11-12 at 11:36 A.M. licensed nurse I was not sure why the resident received Seroquel and was not aware of any behaviors by the resident.

During staff interview on 9-11-12 at 4:10 P.M. licensed nurse G acknowledged the medical record lacked staff monitoring the use of Seroquel for this resident.

The undated facility provided Behavior Monitoring Sheet Policy documented when staff received an order for a medication used for behaviors, staff

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documented on the behavior monitoring sheet in the MAR.

The facility failed to monitor for the efficacy of the antipsychotic medication Seroquel for this resident.

- Resident #29's Admission Minimum Data Set (MDS) 3.0 dated 7/12/12 recorded a Brief Interview for Mental Status Score (BIMS) of 13 indicating the resident had intact cognition. The resident received an antipsychotic medication for 7 days prior to the dated MDS.

The Care Area Assessment dated 7/12/12 documented the resident took a psychotropic medication with possible side effects. He/She had frequent falls at home and was recently admitted to the facility. The resident's mood was stable. Staff would watch for side effects and behaviors while the resident took the antipsychotic medication.

The Abnormal Involuntary Movement Scale (AIMS) dated 7/2/12 recorded no abnormal movements.

The Care Plan dated 7/02/12 for atypical antipsychotic use indicated the resident took Seroquel for the diagnosis of dementia with behaviors and obsessive compulsive disorder (OCD) The potential medication side effects were listed. The care plan directed staff to monitor for target behaviors, but failed to identify what the targeted behaviors were for this medication.

Review of the resident's clinical record revealed

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F 329	Continued From page 35 staff failed to document any behavior monitoring for the seroquel medication. Interview on 9/11/12 at 4:05 P.M. licensed nurse K reported staff should document target behaviors for the seroquel on the behavior monitoring sheet. He/She acknowledged staff failed to document behavior monitoring for this resident's Seroquel. The resident received the medication for the diagnosis of OCD however, he/she did not know what behaviors staff should specifically monitor. The direct care staff should tell the nurse about any resident behaviors. During an interview on 9/11/12 at 4:10 P.M. licensed nurse G reported there should be a behavior monitoring sheet listing the antipsychotic medication the resident received and targeted behavior for the medication, and staff should document the resident behaviors on that sheet. He/She acknowledged staff failed to monitor this resident's behaviors for the seroquel. The facility provided a policy entitled Behavior Monitoring Sheet Policy without a date, directed nursing staff to initiate a behavior monitoring sheet in the Medication Administration Record for residents who received medications for behaviors. The facility failed to monitor for the efficacy of the antipsychotic medications this resident received.	F 329		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental,	F 353		

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and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.

Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 46. Based upon record review, observation and interviews the facility failed to provide sufficient nursing staff to meet the needs of the residents.

Findings include:

- Interview with alert and oriented residents and or their families during stage 1 (9/5-9/6/12) of the survey process stated the facility did not have sufficient nursing staff.

Review of the resident council meeting minutes revealed the following: 10/4/11 residents stated staff did not respond to call lights for 1/2 hour or longer. On 1/10/12 residents commented the

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facility was short staffed. On 8/7/12 residents stated they had to wait a long time for certified nurse aides to assist them.

Review of the facility's alarm response report from 8/30/12 to 9/11/12 at 11:46 A.M. revealed the report included the location and the time staff cleared the page. Further review revealed the report did not include the time the resident activated his/her call light.

On 9/10/12 at 7:31 A.M. an un-sampled resident activated his/her bathroom call light at 7:31 A.M. and staff did not respond to the resident's call light until 7:52 A.M. (duration of 21 minutes).

On 9/10/12 at 7:34 A.M. an un-sampled resident activated his/her call light at 7:34 A.M. and staff did not respond to the resident's call light until 7:56 A.M. (duration of 22 minutes).

On 9/10/12 an un-sampled resident activated his/her call light at 7:36 A.M. and staff did not respond to the resident's call light until 7:51 A.M. (duration of 15 minutes).

On 9/11/12 at 7:34 A.M. an un-sampled resident activated the call light in his/her bathroom. The facility did not respond to the resident's call light until 7:59 A.M. (duration of 25 minutes). At 7:51 A.M. the resident was in the bathroom and the resident stated he/she was waiting for staff to assist him/her off of the commode. The resident's call light remained activated at 7:58 A.M.

During interview with administrative staff A on 9/11/12 at 7:58 A.M. staff stated he/she was not

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aware the resident's call light remained unanswered. Administrative staff A stated his/her cellular telephone was off; therefore he/she did not receive the page the resident's call light remained unanswered.

On 9/11/12 at 7:37 A.M. resident #48 activated the call light in his/her bathroom. The facility did not respond to the resident's call light until 8:00 A.M. (duration of 23 minutes).

During interview with administrative staff A on 9/11/12 at 7:58 A.M. the staff stated he/she was not aware the resident's call light remained unanswered. Administrative staff A stated his/her cellular telephone was off; therefore he/she did not receive the page the resident's call light remained unanswered.

During an interview with nursing administrative staff D on 9/11/12 at approximately 1:00 P.M. staff stated the facility had a wireless call system and when a resident activated his/her call light the page went to all of the certified nurse aides on duty. Nursing administrative staff D stated the page was sent every minute until staff responded to the call light. Nursing administrative staff D stated if the page was not answered within 3 minutes then the page was sent to all licensed nurses, and after 5 minutes he/she and the administrator received the page via their cellular telephones. Nursing administrative staff D stated he/she utilized the report as a quality improvement tool to ensure the facility had sufficient staff and the facility staggered staff to ensure sufficient staffing. Nursing administrative staff D stated the report did not include the time the resident activated the call light and he/she did

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not know how to obtain that information.

During an interview with licensed nurse J on 9/11/12 at 3:40 P.M. staff stated residents expressed concerns regarding staff not answering call lights in a timely manner.

During an interview with resident #48 on 9/11/12 at 3:45 P.M. the resident stated at times staff did not answer call lights in a timely manner and that morning (9/11/12) it took staff a while to answer his/her bathroom call light.

The facility's silent call system policy and procedure (undated) included each certified nurse aide carried a pager which alerted them to calls as they came in. The aide assigned in the area in which the call light was going off, responded first. If the aide assisted someone else, and the light continued to go off, another staff responded. If the light was not turned off in 3 minutes, the system then escalated and paged the charge nurse on duty. The charge nurse sent a staff member or answered the light. If the light was not turned off in 5 minutes, the system escalated and paged the Director of Nursing and Administrator. They answered the light or sent a staff member to respond.

The nursing department staffing policy and procedure (undated) included staffing was assigned/scheduled based on resident's needs. Consideration for assignments and scheduling including duration of call lights, frequency of call lights and acuity of assigned neighborhood.

The facility failed to ensure resident's call lights were answered in a timely manner.

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F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		

The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 46 residents. The sample included 23 residents. Based upon observation, record review and interviews the pharmacist failed to report the irregularity of behavior monitoring and/or the facility failed to act upon the consultant pharmacist's recommendation for 4 (#13, #29, #32, #41) of the 10 residents sampled for unnecessary drugs.

Findings included:

- Review of resident #32's September 2012 Physician Order Sheet (POS) included the resident had diagnoses that included: aggression (hostile behavior), pain, and dementia (loss of brain function) with behaviors. The POS included the resident had a physician's order to receive 1 to 2 tab (tablet) of 325 milligrams (mg) of Tylenol (pain medication) as needed (PRN) for mild to moderate pain, 10 mg of Namenda twice a day (BID) for dementia with behaviors, 125 mg of Depakote Sprinkles BID for aggression and 25

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mg of Seroquel (antipsychotic medication) for aggression.

The resident's quarterly Minimum Data Set (MDS) 3.0 dated 8/6/12 identified the resident scored 9 (moderately impaired cognition) on the Brief Interview for Mental Status, without behaviors and required extensive staff assistance with bed mobility, transfers, locomotion on and off the unit, dressing, toilet use and personal hygiene. The MDS identified the resident received antipsychotic and antidepressant medication 7 days prior to the assessment.

The resident's care plan dated 8/8/12 addressed the resident had dementia with behaviors, aggression, received Seroquel (an antipsychotic medication) and staff monitored the resident for hitting, tearfulness and agitation. The care plan included the resident received Depakote for aggression.

A psychiatrist progress note signed and dated by an Advanced Registered Nurse Practioner on 8/9/12 included staff reported the resident was upset and angry, the resident started receiving Risperdal (an antipsychotic medication) on 7/3/12 due to hitting and screaming at staff. The note included to increase the resident's Namenda, start the resident on Depakote Sprinkles for mood stabilization and aggression, discontinue the Risperdal and start Seroquel for aggression.

A consultant pharmacist's medication regimen review dated 6/14/12 included the resident had physician's orders to receive 1 to 2 tabs of Tylenol PRN every 4-6 hours and the pharmacist asked how did nursing staff consistently

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determine whether to give the resident 1 or 2 tabs and to consider changing or clarifying the order.

The consultant pharmacist's monthly medication regimen reviews dated 5/10/12, 6/14/12, 7/16/12 and 8/15/12 did not include irregularities regarding behavior monitoring.

Review of the resident's September 2012 Medication Administration Record (MAR) revealed the resident received (2) 325 mg of Tylenol on 9/3/12 at 1:30 P.M. for back pain. Further review revealed staff failed to rate the resident's pain before or after staff administered the Tylenol. According to the MAR the resident received 325 mg of Tylenol on 9/7/12 at 3:40 P.M. Further review revealed staff failed to rate the resident's pain prior to administering the Tylenol to determine if the resident required 1 or 2 tabs of the Tylenol.

Review of the resident's September 2012 behavior monitoring sheet included the facility monitored the resident for yelling, anxiety and aggression. The behavior monitoring sheet did not identify the medication for the targeted behaviors.

On 9/11/12 at 10 A.M. the resident laid in bed and spoke to a nursing student and the resident had no inappropriate behaviors.

During an interview with licensed nurse I on 9/11/12 at approximately 1:25 P.M. the staff stated the behavior monitoring sheet listed the resident's behaviors the facility monitored and the behaviors were not associated with any medications. Licensed nurse I stated the resident

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was combative at times and the resident's behaviors associated with his/her dementia included hitting and kicking and confirmed staff did not include those behaviors on the behavior monitoring sheet.

During an interview with nursing administrative staff D on 9/11/12 at approximately 1:00 P.M. the staff stated behavioral monitoring sheets were not drug specific and if a resident received Depakote for behaviors the resident would not have a behavioral monitoring sheet. Nursing administrative staff stated residents that received an antipsychotic medication would have a behavioral monitoring sheet but it would not be drug specific. Nursing administrative staff D confirmed the facility did not identify the medication associated with the targeted behavior.

During an interview with nursing administrative staff D on 9/11/12 at approximately 3:10 P.M. the staff stated the resident's MAR should read if staff rated the resident's pain between 1 to 5, staff administered 1 tab of Tylenol and if the resident's pain was greater than 5, staff administered 2 tabs of Tylenol. Nursing administrative staff D confirmed the MAR did not include a pain rating scale to determine the dosage of Tylenol for staff to administer. The staff confirmed the facility failed to act upon the pharmacist's recommendation.

The consultant pharmacist failed to address the efficacy of the resident's medications in regards to behavior monitoring and the facility also failed to act upon the consultant pharmacist's recommendation to rate the resident's pain for the administration of the appropriate dose of Tylenol.

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- Review of resident #41's Physician Order Sheet (POS) signed 8/6/12 included the resident received 250 milligrams (mg) of Depakote ER (extended release) three times a day for dementia with behaviors and 7.5 milligrams of Zyprexa (an antipsychotic) each day.

The resident's quarterly Minimum Data Set (MDS) 3.0 dated 7/11/12 revealed the resident had short and long term memory problems, moderately impaired decision making skills, required staff supervision with locomotion on and off the unit, dressing, personal hygiene and limited staff assistance with toilet use. The MDS identified the resident received antipsychotic and antidepressant medications 7 days prior to the assessment reference date.

The resident's psychotropic drug use care area assessment dated 1/25/12 included the resident received antipsychotic medications and had a diagnosis of Alzheimer's with behaviors.

The resident's care plan dated 7/12/12 included the resident received Zyprexa and Depakote.

The consultant pharmacist's monthly medication regimen reviews dated 9/19/11, 10/3/11, 12/8/11, 1/11/12, 2/9/12, 3/9/12, 4/17/12, 5/10/12, 6/13/12, 7/16/12 and 8/15/12 did not include irregularities regarding behavior monitoring.

The resident's June 2012 behavior monitoring sheet included the resident received Zyprexa for paranoia (condition of suspicious behaviors). The

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resident's September 2012 behavior monitoring sheet included anger as the targeted behavior for Zyprexa.

Review of the resident's clinical record lacked evidence to support the facility monitored the resident's behaviors associated with dementia with behaviors. The clinical record also lacked evidence to support the facility monitored targeted behaviors for the Depakote.

On 9/10/12 at 2:10 P.M. the resident attended bible studies and did not display any inappropriate behaviors.

Interview with licensed nurse F on 9/10/12 at approximately 2:05 P.M. the staff stated the facility did not monitor behaviors associated with Depakote. Licensed nurse F stated the resident became angry and was aggressive with staff at times if staff attempted to redirect the resident.

Interview with nursing administrative staff D on 9/11/12 at approximately 1:00 P.M. the staff stated behavioral monitoring sheets were not drug specific and if a resident received Depakote for behaviors the resident would not have a behavioral monitoring sheet. Nursing administrative staff stated residents that received an antipsychotic medication would have a behavioral monitoring sheet but it would not be drug specific. Nursing administrative staff D confirmed the facility did not identify the medication associated with the target behavior.

The facility's behavior monitoring sheet policy (undated) included any nurse who initiated an order for a medication for behaviors initiated

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behavior charting via behavior monitoring sheet in the MAR.

The consultant pharmacist failed to address the efficacy of the resident's medications in regards to behavior monitoring.

- Resident #13's quarterly Minimum Data Set 3.0 Assessment (MDS) dated 6-14-12 documented the resident with a Brief Interview for Mental Status Score score of 15, which indicated the resident was independent with decision making and was cognitively intact, required extensive assistance with bed mobility, locomotion, personal hygiene and required total assistance with transfers, toilet use and bathing.

The 3-19-12 Psychosocial Drug Use Care Area Assessment (CAA) documented the resident received antidepressants, a hypnotic, antianxiety, and psychotropic medications with possible side effects, and his/her mood varied.

The updated 7-23-12 care plan documented the resident received antianxiety, antidepressant, hypnotic, and pain medication and directed his/her own care.

The updated 6-13-12 Atypical Antipsychotic Use form in the care plan documented the resident received Abilify for bipolar diagnosis (a psychiatric disorder) and staff encouraged activities, 1:1 visits, TV, and directed staff to report negative comments, remind the resident not to scream at staff or call them names, inform the charge nurse when behavior was inappropriate, and the resident became upset at times when he/she had

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to wait for smoking time. The Targeted Behavior section of the facility form documented the resident received Valium for the diagnosis of anxiety and insomnia. The resident napped after lunch, requested antianxiety medication as needed and staff encouraged the resident to express his/her concerns, feelings, and fears.

The September 2012 Medication Administration Record (MAR) revealed the resident received Depakote 750 milligrams (mg) twice (BID) daily for bipolar, Effexor 75 mg BID for depression, Valium 1 mg three (TID) times daily for anxiety, Abilify 5 mg daily for bipolar, and Cymbalta 30 mg daily for depression.

The nurse's note (NN) dated 5-10-2 at 1:00 P.M. documented the resident was rude and threatened to hit staff.

The NN on 5-19-12 at 11:00 A.M. documented the resident became upset and yelled at staff.

The NN on 8-24-12 at 2:30 P.M. documented the resident had increased episodes of yelling and made inappropriate comments to staff.

The July, August, and September 2012 Behavior Monitoring Sheets documented the behavior of anxiety and the resident received Abilify, had insomnia, had anxiety and received Valium, and had outbursts. The clinical record lacked evidence the facility monitored specific behaviors related to the use of the antipsychotics, antidepressants and antianxiety medications.

Record review of the July 2012 Consultant Pharmacist's Medication Regimen Review

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documented the recommendation for a gradual dose reduction for the resident's Effexor and Cymbalta medications. The resident's clinical record lacked evidence the facility acted upon the recommendation with the physician and lacked evidence the pharmacist consultant identified the lack of behavior monitoring for the resident's antipsychotics, and antianxiety medication.

Observation on 9-10-12 at 9:15 A.M. revealed the resident sat in a wheelchair outside on the patio and smoked a cigarette. The resident was calm and talkative.

Staff interview on 9-11-12 at approximately 1:36 P.M. licensed nurse I reviewed the MAR and stated staff documented behaviors displayed by the resident on the behavior monitoring flow sheet in the MAR.

During staff interview on 9-11-12 at 1:40 P.M. pharmacy consultant staff S stated he/she recommended a gradual dose reduction for the resident's use of Effexor and Cymbalta and did not have evidence the facility acted on the recommendation.

During staff interview on 9-11-12 at 3:30 P.M. administrative nursing staff C acknowledged the behavior monitoring sheet lacked specific behaviors related to each medication used for the behaviors the resident displayed which required the medication.

During staff interview on 9-11-12 at approximately 4:20 P.M. administrative nurse D acknowledge the clinical record lacked evidence the facility acted upon the consultant pharmacist's

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recommendations.

The facility failed to act upon the recommendations of gradual dose reduction by the consultant pharmacist to monitor specific targeted behaviors for this resident who received multiple antipsychotic, antianxiety, and antidepressant medication and failed to identify the lack of monitoring for the resident's antipsychotic and antianxiety medication.

- Resident #29's Admission Minimum Data Set (MDS) 3.0 dated 7/12/12 recorded a Brief Interview for Mental Status Score (BIMS) of 13 indicating the resident had intact cognition. The resident received an antipsychotic medication for 7 days prior to the MDS date.

The Care Area Assessment dated 7/12/12 documented the resident took a psychotropic medication with possible side effects. The resident had dementia with behaviors, Alzheimer's disease, anxiety and obsessive compulsive disorder. He/She had frequent falls at home and was recently admitted to the facility. The resident's mood was stable. Staff would watch for side effects and behaviors while the resident took the antipsychotic medication.

The Abnormal Involuntary Movement Scale (AIMS) dated 7/2/12 recorded no abnormal movements.

The Care Plan dated 7/02/12 for atypical antipsychotic use indicated the resident took Seroquel for the diagnosis of dementia with behaviors and obsessive compulsive disorder

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(OCD) (behavior to repetitively perform certain acts or carry out rituals). The potential medication side effects were listed. The care plan directed staff to monitor for target behaviors, but failed to identify what the targeted behaviors were for this medication.

Review of the resident's clinical record revealed staff failed to document any behavior monitoring for the seroquel medication.

Review of the Consultant Pharmacy Medication Regimen Review dated 7/17/12 revealed the consultant recommended pain monitoring for scheduled Tylenol however, failed to recommend behavior monitoring for the Seroquel.

The Consultant Pharmacist's Medication Regimen Review dated 8/15/12 failed to recommend behavior monitoring for the Seroquel.

During an interview on 9/11/12 at 4:05 P.M. licensed nurse K reported staff should document target behaviors for the Seroquel on the behavior monitoring sheet. He/She acknowledged staff failed to document behavior monitoring for this resident's Seroquel. The resident received the medication for the diagnosis of OCD however, he/she did not know what behaviors staff should specifically monitor. The direct care staff tell the nurse about any abnormal resident behaviors.

During an interview on 9/11/12 at 4:10 P.M. licensed nurse G reported there should be a behavior monitoring sheet listing the antipsychotic medication the resident received, target behavior for the medication, and staff were to document the behaviors on that sheet. He/She

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F 428	Continued From page 51 acknowledged staff failed to act upon the pharmacist's recommendations. The facility failed to act upon the consultant pharmacist recommendations.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431		

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F 431	Continued From page 52 be readily detected. This REQUIREMENT is not met as evidenced by: The facility identified a census of 46 residents. Based on observation, record review, and interview the facility failed to record the open date on 2 of 5 insulin pens in 1 of 1 medication storage rooms for 1 of 4 days on site of the survey. Findings included: - On 9-5-12 at 9:45 A.M. observation revealed 2 Lantus Insulin pens opened, available for use, and not dated with the open date. At that time during an interview, licensed nurse H acknowledged the pens were not dated and stated that staff should date the pens when opened. The undated facility provided Procedure for Storing Medications Policy and Procedure documented staff dated and initialed Insulin pens when opened. The facility failed to document the open date on 2 Lantus Insulin pens available for use for 2 unsampled residents.	F 431		